STATE OF WISCONSIN

Medicare+Choice – Questions and Answers

OFFICE OF THE COMMISSIONER OF INSURANCE PI-099 (R 09/2003)

Introduction

This pamphlet provides basic information to persons age 65 and over, and some disabled individuals under age 65, about the Medicare+ Choice program. The Medicare+Choice program was enacted in 1997 to foster a Medicare program that relies on health maintenance organizations and managed care plans to lower the costs of the Medicare program.

The Office of the Commissioner of Insurance (OCI) publishes two other booklets to help people make decisions about their regular Medicare coverage. If you need more information on Medigap (also called Medicare supplement) insurance policies approved in Wisconsin, contact the Commissioner's Office and request a copy of the booklets *Wisconsin Guide to Health Insurance for People with Medicare* and *Medicare Supplement Insurance Approved Policies*. These are available on OCI's Web site http://oci.wi.gov or can be obtained from our office by calling the toll-free number 1-800-236-8517.

What is Medicare+Choice?

Medicare+Choice has been added to the Medicare program. Medicare is the federal health insurance program for senior citizens and certain other qualifying people. Regular Medicare includes Part A, which covers hospitalization, skilled nursing facility care, home health and hospice care. Medicare Part B, which is purchased at your option, covers physician services, therapies, diagnostic tests, and outpatient hospital services. You may also purchase a supplemental policy to cover deductibles, coinsurance, and some other Medicare noncovered services.

Medicare+Choice offers people enrolled in Medicare Part A and Part B options for obtaining health services through the Medicare program. It is important to know that **you may choose to stay in regular Medicare if you are satisfied with that program**, and that all Medicare+ Choice plans must provide at least the same benefits as traditional Medicare. Medicare+ Choice plans are not required to provide the same supplemental benefits that are provided under Medicare supplement policies available in Wisconsin.

Under Medicare+Choice, the Medicare program will, at your direction, purchase a health insurance policy on your behalf. Before Medicare will agree to pay for a policy, the policy must meet minimum state and federal requirements for licensure, benefits offered, access to providers, quality of care, and reporting. However, Medicare+Choice plans are annual contracts and are not guaranteed renewable as is required for Medicare supplement policies. As with Medicare supplement policies, the premiums you pay for the Medicare+Choice plan may increase. You may also be responsible for paying your doctor and hospital bills if you do not follow the Medicare+Choice plan's rules.

What are the options under Medicare+ Choice?

Insurance companies offering Medicare+ Choice health plans in Wisconsin must be licensed as an insurance plan before Medicare will enter into an arrangement to purchase coverage for you. The Medicare+Choice plans are based on your geographic location and are not available in all Wisconsin counties. The types of Medicare+Choice plans available in Wisconsin are:

- **Health Maintenance Organization (HMO):** A type of managed care health plan with a defined list of providers, often referred to as a network, that enrollees **must** use. HMOs generally have more restrictions on the providers you may use than any other types of health plans in which you can enroll, although they often provide benefits, such as preventive care, that are not available from other types of health plans.

  Normally, an HMO will only make referrals to non-network providers in unusual situations. The HMO may also require that you obtain a referral from your primary provider before seeing a specialist. Other than in an emergency situation, an HMO will not pay for services you obtain from a provider who is not part of the HMO's network. Before you enroll in an HMO, you should carefully review the list of providers that is available through the HMO. You should also review whether the HMO allows access to out-of-state provider networks. HMOs do not cover services provided by non-network providers that are not emergency or urgent care situations.

- **Point of Service Plan (POS):** A type of managed care health plan with a network of providers that also permits you to use non-network providers, usually at some additional cost to you. The POS plan may also have requirements that you obtain a referral from your primary provider **before** the plan will agree to pay for out-of-network care.

- **Private Fee for Service (PFFS):** A type of health plan offered by private health insurance companies. The plan allows you to go to any health care provider who accepts Medicare assignment or participates in the Medicare program but charges in excess of the Medicare assignment amount, **and** who accepts the PFFS's fee schedule. If you see a provider who does not accept Medicare assignment, you may be responsible for any charges that are up to 15 percent in excess of the Medicare allowed amount. If you see a provider who does not accept the PFFS's fee schedule or who does not participate in the Medicare program, you will not be covered and will be responsible for the entire amount charged by the provider. The plan may charge you, through premiums, additional out-of-pocket expenses, or both, for any costs that exceed what traditional Medicare would pay.

Other Medicare+Choice options you may hear about are:

- **Medicare Medical Savings Account (MSA):** A health plan option made up of two parts. One part is a high deductible insurance health policy. The other part is a special savings account where Medicare deposits money to help you pay for expenses to meet the deductible. The deductible may be as high as $6,000 annually.

- **Preferred Provider Plans (PPP):** A type of managed care health plan offered by private health insurance companies that pays a specific level of benefits if certain providers are used, and a lesser amount if

non-PPP providers are utilized. Like an HMO, a PPP operates in a certain geographic area and is limited to specific providers.

How do I choose among the different plans?

Remember, you do not have to leave traditional Medicare unless you choose to. The cheapest policy may not be the best option for you. Some things you may want to consider if you decide to choose a Medicare+Choice plan include:

1. What providers are available to you?

2. Will the plan allow you to see the providers you want?

3. Are there any additional benefits that may be offered, and is there an additional charge for these benefits?

4. What are the benefits that are excluded but would be covered under a traditional Medicare supplement policy?

5. What is the total cost to you, including premiums, coinsurance, copayments, deductibles, or other out-of-pocket expenses?

6. How often and by how much can the plan raise your premiums?

7. If you have a specific health condition, is one type of plan better suited to provide the services you need?

Generally, plans that offer you more freedom of choice of providers or cover additional benefits will cost you more.

What happens under Medicare+Choice if I have a medical emergency?

All Medicare+Choice plans are required to use what is known as the "prudent layperson" standard in making coverage decisions about emergency care. Under this standard, if you have acute symptoms, such as severe pain, that would cause a reasonably prudent layperson to expect that delay in treatment would cause serious jeopardy to health or impairment of bodily functions, you are permitted to obtain emergency services without prior approval from your health plan. Emergency services must be provided by a qualified provider and are limited to services needed to diagnose and stabilize your condition.

Urgent care is also required to be covered by a Medicare+Choice plan. An urgent care situation would include an accident or sudden illness while you are away from home. If you are a frequent traveler, you should inquire about the plan's guidelines for services when you are out of its geographic service area, including refills on prescription drugs and access to non-urgent or emergency medical services. Your Medicare+ Choice plan may have a passport provision allowing you to see providers in other parts of the country, if the plan provides this benefit. Under a PFFS plan your coverage is not limited by geographic service area. If you need medical attention, you may go to any doctor, specialist, or hospital that is approved for Medicare and accepts the plan's payment terms.

What information should I ask for from a Medicare+Choice organization?

Medicare+Choice plans must give you in writing all the information on the list below. If this information is not included in the plan's enrollment materials, you may call the plan and request it.

1. Grievance and Appeal Procedures, or what happens if you are dissatisfied with a coverage decision made by your health plan. There are minimum requirements that all plans must meet.

2. Outline of Coverage, or a summary of benefits provided by the plan indicating the scope of coverage offered by the plan.

3. Prior Authorization Rules, or what you have to do to obtain specialty care or care from a non-network provider.

4. Procedures to Protect Patient Confidentiality, or how the plan makes sure no one sees your medical records that should not.

5. Provider Directory, or a list of providers who are contracted with the plan to provide services. This list could include clinics and hospitals available to plan enrollees.

What happens if I am unhappy with my Medicare+Choice plan?

A Medicare+Choice plan decision regarding the type of service and the amount to reimburse for the service is known as an organization determination. Medicare+Choice plans are required to respond in a timely manner to appeals of organization determinations. Medicare+Choice plans are also required to provide you with written information on how to file an appeal.

1. If you are unhappy with an organization determination, you must first file a request for reconsideration with the Medicare+ Choice plan. The plan must issue its decision on your request within 60 calendar days and must issue an expedited decision within 72 hours.

2. If you are still unhappy with the decision, you may then appeal to an independent reviewer. The time frames are the same as those described above.

3. Additional reviews are conducted by an administrative law judge, the Department of Health and Human Service's appeals counsel, and finally, may be appealed in federal court.

4. If the organization determination affects coverage of a continuing inpatient hospital stay, it may be immediately appealed to a Medicare peer review organization. You are not responsible for any costs incurred while this decision is pending.

If you are unhappy with a plan decision to not expedite an appeal or with the way you have been treated by plan providers, you should file a grievance with your Medicare+Choice plan. Grievances are separate and different from appeals. A plan is required to explain its grievance process to you and to respond to your grievance in a timely fashion.

Am I allowed to change Medicare+Choice plans?

Under most Medicare+Choice options, you will be allowed to change plans monthly until 2005. To change plans you simply file an enrollment form with the new plan and coverage is effective at the start of the next month.

Medicare+Choice plans are required to have open enrollment periods for the month of November of each year. If you are happy with your current plan, you do not have to do anything.

Can my Medicare+Choice plan drop me?

Medicare+Choice plans can drop you at the end of the plan year if the plan does not renew its contract with Medicare. A plan that does not renew its contract with Medicare may decide to drop select geographic areas of service, or it may decide to nonrenew the entire plan. A plan may involuntarily disenroll you for failure to pay premiums timely, for causing a disruption in the plan's ability to deliver health care services, or if it cannot meet your medical needs. If you are involuntarily disenrolled, you are automatically returned to coverage under traditional Medicare at the beginning of the month following your involuntary disenrollment.

Am I entitled to the mandated benefits required by Wisconsin insurance law under Medicare+Choice plans?

Medicare+Choice policies are not subject to the mandated benefit requirements under Wisconsin insurance law. Insurance laws in Wisconsin mandate the coverage of specific services, including diabetic supplies and limited home health care and skilled nursing care. You can obtain a copy of a pamphlet that explains the benefits mandated under Wisconsin insurance law by contacting OCI.

I don't understand all the terms associated with Medicare+Choice

Here is a list of some of the terms you are likely to hear with Medicare+Choice plans.

Appeal: Process for resolving a dispute about a Medicare+Choice plan's failure to provide benefits you believe are Medicare covered services.

Benefit Determination: A decision from the Medicare managed care plan to offer coverage under the provisions of the policy. The benefit could require a deductible or copayment. The benefit could also be capped at a certain amount by the plan.

Coordinated Care Plan: Any form of Medicare+Choice plan that relies on a provider network to deliver care to enrollees, including HMO and POS plans. Most coordinated care plans will make you pay for all or part of the cost of using a provider who is not part of their network.

Coverage: Services that meet the plan requirements for reimbursement. A medical service is not necessarily covered, even if your health care provider says you need it, unless the service meets the terms of the insurance policy.

Disenrollment: Leaving a Medicare managed care plan to go to another insurance plan. There are certain plan rules that must be followed in order to leave the plan officially. Your disenrollment will be effective the first of the month following the submission of your disenrollment form.

Disenrollment form: The form necessary to submit to your present Medicare managed care plan indicating your decision to leave the plan. This could be a simple written statement from you to the insurer, or you can get this form from your local Social Security office or from the plan in which you are presently enrolled.

Emergency Services: Services delivered by an appropriately trained health care professional that are required to diagnose and stabilize an emergency condition.

Grievance: A written complaint from you or from an individual on your behalf filed with the plan involving issues such as waiting periods, physician behavior, involuntary disenrollment situations, quality of service, and premiums.

Mandatory Supplemental Benefits: Additional benefits included in Medicare coordinated care plans that are required to be purchased by you.

Medicare+Choice Eligible Individual: Anyone eligible for Medicare Part A and enrolled in Medicare Part B who is not receiving end stage renal disease (ESRD) benefits.

Medicare+Choice Organization: A private or public entity that agrees to meet the contractual requirements to offer a Medicare+Choice health plan. A Medicare+Choice organization may offer more than one plan or type of plan.

Medicare+Choice Plan: An insurance policy offered by a Medicare+Choice organization.

Open Enrollment Period: Period during which individuals may elect to change their plan.

Optional Supplemental Benefits: Additional benefits offered by Medicare coordinated care plans that you may choose and that may include additional premiums.

Organization Determination: Decision by a Medicare+Choice organization regarding the amount of service provided or the price the plan will reimburse for the service.

Out-of-pocket Expenses: Expenses paid by you in addition to plan premiums, which may include any or all of the following:

a) **Deductible:** Fixed amount paid for covered services prior to the plan making payments. Deductibles are usually required to be paid annually. Expenses counted towards your Medicare deductible are the amounts that Medicare would pay for the service, not what you may have actually paid.

b) **Copayment:** Fixed dollar amount for use of medical services. For example, many health plans require that you pay a fixed dollar amount for each drug prescription you receive.

c) **Coinsurance:** A fixed percentage of the total cost of services, paid each time you use the service.

Your health plan may have an annual cap on total out-of-pocket expenses. This information is included in your initial enrollment materials.

Passport Plan: A network of providers who are outside of your plan's geographic service area, usually in a different state, which can be used by you in non-emergency or urgent care situations. Some managed care plans have these networks available to individuals who travel to certain states. Check with your plan on the availability of this provision.

Plan Determination: Decision by a Medicare+Choice plan regarding the amount of service it will provide you or the price the plan will reimburse the provider for the service.

Service Area: Most coordinated care plans operate in a limited geographic area known as a service area. It is usually stated as county or zip code of operation.

Urgent Care: Covered services when you are temporarily out of the area **and** that are medically necessary and immediately needed as a result of an unforeseen illness, accident, or injury, and when it is not reasonable to obtain services from a network provider.

Conclusion

Remember, if you are happy with your current coverage, you don't have to make a change.

If you want to switch to a Medicare+Choice plan, read all the materials from the plan carefully before enrolling. You should also contact the plan's customer service department before enrolling in the plan. Each plan should provide written information on covered benefits, total costs to you, lists of available providers, and restrictions on access to providers. If it is important to you to stay with a specific doctor or hospital, you should make sure that provider is part of the health plan you choose.

If you have internet access, you can review periodic updates to this pamphlet on OCI's Web site at http://oci.wi.gov

Other Resources Available Regarding Medicare Supplement and Medicare+ Choice Plans

The federal government has made arrangements with the Board on Aging and Long-Term Care to provide additional information on Medicare+Choice plans. You may reach them at **1-800-242-1060** or on the Web at http://longtermcare.state.wi.us/home/publications.htm.

In addition, you can obtain information at **1-800-MEDICARE** or on the CMS Medicare Web site at http://www.medicare.gov. The regional telephone number is (312) 353-7180.

Where to Go for Help

If you have a specific complaint about your insurance, refer it first to the insurance company or agent involved. If you do not receive satisfactory answers, contact the Office of the Commissioner of Insurance.

For your convenience, a complaint form is included in OCI's Web site, **http://oci.wi.gov**. For information on how to file insurance complaints call:

(608) 266-0103 (In Madison) or
1-800-236-8517 (Statewide)

Mailing Address
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

Electronic Mail
complaints@oci.state.wi.us
(please indicate your name, phone number, and e-mail address)